



AIH-Cedar Park

715 Discovery Blvd. Suite 412 | Cedar Park, TX 78613

AIH-Central Austin

1305 West 34th Street Suite 407 | Austin, TX 78705

Tel: (512) 260-1710 | Fax: (512) 986-6077 | Email: info@achieveih.com

Patient Name:

DOB:

Date:

NEW PATIENT FORMS

Sex: Male Female | Height: | Weight: | State: | Zip:

Address: | City:

E-mail

Phone #: (H) (W) (C) Can we leave a message, if you are not available? Yes No

Occupation: Can we call you at work? Yes No

Preferred Method of Communication: Phone Call Text Message Email

Marital Status: Single Married Divorced Widowed Separated Minor

EMERGENCY CONTACT: Name: Relationship: Phone #:

How did you hear about us? Community Impact Drive-by Dinner Talk Postcard mailing Neighborhood Newsletter
 internet search: _____ Referral/Other: _____

INSURANCE INFORMATION

Policy Holder Name: DOB:

Relationship to patient (if other than self): Phone of Policy Holder:

PRIMARY INSURANCE CO.: Customer service #:

Member ID#: Group#:

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR DRIVER'S LICENSE & INSURANCE CARD(S)

ASSIGNMENT AND RELEASE (INSURED PATIENTS ONLY)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE ACUPUNCTURE OFFICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient/Guardian signature _____ Date _____

Have you been to a Physician within the past year for any of your health problem(s)?

I (*patient's name*) _____, am notifying the medical providers, of the following:

Yes No I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.
_____ (*initials of patient/guardian*) Date: _____

Yes No I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated.

If you have checked NO for both boxes above, legally we are required to refer you be evaluated by a physician prior to starting your acupuncture treatments. It is YOUR responsibility and YOUR choice whether to follow this advice.

Patient/Guardian signature _____ Date _____

Acupuncturist's signature _____ Date _____

Patient Name: _____

DOB: _____

Date: _____

HEALTH HISTORY

MAIN COMPLAINTS		Intensity	
If you could get rid of any health problems what would you want to get rid of. (<u>please list in the order of importance below</u>), and we will let you know if we can help.		On a scale of "1 to 10", please rate the intensity of your chief complaint (0 = no discomfort , 10 = extreme discomfort)	
		on AVERAGE your complaint is	at WORST your complaint is:
1.		0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
2.		0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
3.		0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
4.		0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
5.		0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
6.		0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Onset		What have you tried doing to resolve these problems that DID NOT work?	
For each condition listed above, please mark when it first began, or when you started experiencing them?		The definition of "did not work" is you tried a treatment and you still experience the symptom(s) or still have the health problem or your labs/tests are only normal because you are taking medication(s) or the treatment did not restore your body's own ability heal itself.	
1	Date began:		
2	Date began:		
3	Date began:		
4	Date began:		
5	Date began:		
6	Date began:		
Frequency		Duration	
Please check the box that best represents how frequent you feel your chief complaint(s):		when you are feeling your symptoms, how long do your symptoms last?	
1	<input type="checkbox"/> daily <input type="checkbox"/> ___ day(s) per week <input type="checkbox"/> ___ day(s) per month <input type="checkbox"/> ___ times per month <input type="checkbox"/> Other:	<input type="checkbox"/> mins <input type="checkbox"/> hours <input type="checkbox"/> days <input type="checkbox"/> constant	
2	<input type="checkbox"/> daily <input type="checkbox"/> ___ day(s) per week <input type="checkbox"/> ___ day(s) per month <input type="checkbox"/> ___ times per month <input type="checkbox"/> Other:	<input type="checkbox"/> mins <input type="checkbox"/> hours <input type="checkbox"/> days <input type="checkbox"/> constant	
3	<input type="checkbox"/> daily <input type="checkbox"/> ___ day(s) per week <input type="checkbox"/> ___ day(s) per month <input type="checkbox"/> ___ times per month <input type="checkbox"/> Other:	<input type="checkbox"/> mins <input type="checkbox"/> hours <input type="checkbox"/> days <input type="checkbox"/> constant	
4	<input type="checkbox"/> daily <input type="checkbox"/> ___ day(s) per week <input type="checkbox"/> ___ day(s) per month <input type="checkbox"/> ___ times per month <input type="checkbox"/> Other:	<input type="checkbox"/> mins <input type="checkbox"/> hours <input type="checkbox"/> days <input type="checkbox"/> constant	
5	<input type="checkbox"/> daily <input type="checkbox"/> ___ day(s) per week <input type="checkbox"/> ___ day(s) per month <input type="checkbox"/> ___ times per month <input type="checkbox"/> Other:	<input type="checkbox"/> mins <input type="checkbox"/> hours <input type="checkbox"/> days <input type="checkbox"/> constant	
6	<input type="checkbox"/> daily <input type="checkbox"/> ___ day(s) per week <input type="checkbox"/> ___ day(s) per month <input type="checkbox"/> ___ times per month <input type="checkbox"/> Other:	<input type="checkbox"/> mins <input type="checkbox"/> hours <input type="checkbox"/> days <input type="checkbox"/> constant	
What Aggravates or Alleviates your Chief Complaints?			
What AGGRAVATES each of the complaints above?		What ALLEVIATES each of the complaints above?	
1			
2			
3			
4			
5			
6			



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How are your health problems interfering with the following areas of your life?

Table with 2 columns: Area (Work, Family, Hobbies, Life) and Interference description.

How have you taken care of your health in the past?

- Medications, Dietary Modifications, Chiropractic, Surgery, Vitamins & Supplements, Arrosti / Active Release Therapy, Injections, Acupuncture, Massage, Exercise, Chinese Herbal Medicine, Other: _____

How did the previous methods work for you? _____

ARE YOU HERE VISITING US, BECAUSE YOU: (please choose one)

- a) Just want to get some Relief from your symptoms, and then you'll manage the rest with medication
b) Want to Find & Correct the Root Cause of your Health problem(s), if possible, and Start a Lifestyle program for optimized living where your body can heal itself without medications or be less dependent upon medications.
c) Other: _____

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short!)

Blank lines for writing the response to the 3-year projection question.

What potential barriers do you foresee that would prevent you from achieving your Health Goals? _____

Do you feel it is possible to eliminate or prevent these potential barriers? _____

Rate on a scale of 1-10 (1 being lowest, 10 being highest):

- How important is it for you to resolve your health concerns?
Do you feel that you are coachable and would enjoy a mentor in helping you?
Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

ARE YOU PREGNANT? : []Yes []No []If yes, how far along? _____

Do you exercise: []Never []Daily []Weekly []Monthly Explain: _____

Do your work activities mostly involve: [] Sitting (time:) [] Standing (time:) [] Light Labor [] Heavy Labor

What is your daily/weekly intake of the following: Caffeine _____ Alcohol _____ Nicotine/Tobacco _____

Illicit Drugs: []Yes []No Comments _____

Patient Name: _____

DOB: _____

Date: _____

IMAGING & TESTS	DATE (S)	RESULTS (list area that was imaged)
X-ray (s)		
MRI (s)		
CT (CAT) Scan (s)		
Ultrasound (s)		
Cholesterol		
Blood Sugar		
Mammagram		
PAP Smear		
Blood Tests (which?)		
Nerve Conduction		

Please check to indicate if you have ever had any of the following:

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Infertility | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Skin Disorders (rash, eczema, psoriasis) |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pacemaker, Defibrillator | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes (Type 1 / 2) | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Paralysis / Semi-paralysis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease (bronchitis, pneumonia, emphysema) | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Thyroid Disease (hyperthyroid, hypothyroid) |
| <input type="checkbox"/> Bladder Diseases (UTI, IC) | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Blood pressure (too high / too low) | <input type="checkbox"/> Gout | | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease | | | |
| | <input type="checkbox"/> Hepatitis | | | |

Please list ALL health care providers (family physicians, surgeons, specialists, chiropractors, etc.) currently treating you:

List ALL disorders you are CURRENTLY being treated for (include the dates of when you were diagnosed):

List ALL types of Surgeries you have had in the past (Include Dates):

List ALL Accidents and/or Hospitalizations you have had in the past (Include Dates):

List ALL Allergies (Food, Medications, Pollen, etc):

List ALL Medications (prescription & over-the-counter) you are CURRENTLY taking (include duration of use & Dosage):

List ALL Nutritional Supplements, Herbs, or vitamins you are currently taking:

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Date: _____

LIST ALL MEDICAL CONDITIONS OF YOUR IMMEDIATE FAMILY:

	MOTHER	FATHER	BROTHERS	SISTERS
age if living				
if deceased, cause of death				
Cancer (s)				
Diabetes				
Heart Disease				
Stroke				
Autoimmune Disorders				
Mental Illness				
Other				

We find that when all of your healthcare providers are up to date with your treatment progress, it makes it easier for all of us to better help you improve your health. Is it okay if we contact the above healthcare providers to update them on the treatments you are receiving here? yes no

IMPORTANT: Complete these documents as thoroughly as possible, please be honest with yourself. Some of the questions that follow may seem unrelated to your condition, BUT they may play a major role in diagnosis and treatment. **All information is strictly confidential.**

please check all symptoms that you experience either ACUTELY or CHRONICALLY

<p style="text-align: center;">LUNG System Function <i>(Large Intestine, Thyroid, Thymus)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing / Difficulty Breathing / Heaviness in chest / Asthma <input type="checkbox"/> Easily catch colds / Chronic Infections <input type="checkbox"/> Nasal / Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Cough (dry / productive / blood / persistent) <input type="checkbox"/> Snoring <input type="checkbox"/> Loss of Smell / Taste <input type="checkbox"/> Dry Nose / Mouth <input type="checkbox"/> Dry / Sore Throat <input type="checkbox"/> Dry Skin <input type="checkbox"/> Allergies, Sneezing <input type="checkbox"/> Alternating fever & chills <input type="checkbox"/> Excessive Sweating <input type="checkbox"/> Difficult Sweating <input type="checkbox"/> Headaches <input type="checkbox"/> Stiff Neck & Shoulders <input type="checkbox"/> Chronic sadness <input type="checkbox"/> Constipation / Difficult Defecation <input type="checkbox"/> hemorrhoids / Blood / Mucous in Stools 	<p style="text-align: center;">SPLEEN System Function <i>(Stomach, Pancreas)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Low appetite <input type="checkbox"/> fatigue after eating <input type="checkbox"/> Loose stools / Diarrhea <input type="checkbox"/> undigested food in stool <input type="checkbox"/> Abrupt Weight Gain <input type="checkbox"/> Abrupt Weight Loss <input type="checkbox"/> Abdominal Bloating / Gas <input type="checkbox"/> Gurgling noise in stomach <input type="checkbox"/> Bleeding, swollen/painful gums <input type="checkbox"/> Heartburn / Acid Regurgitation <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Frequent Belching / hiccups <input type="checkbox"/> Frequent / Constant Hunger <input type="checkbox"/> Stomach pain <input type="checkbox"/> Bad breath <input type="checkbox"/> Canker sores in the mouth <input type="checkbox"/> Bruise easily <input type="checkbox"/> Always worrying / over-thinking everything <input type="checkbox"/> Weak / Atrophy in muscles <input type="checkbox"/> whole body feels heavy <input type="checkbox"/> Fluid retention (edema, heavy limbs & body) <input type="checkbox"/> Swollen feet / Legs / Joints
<p>HEART System Function <i>(Pituitary Gland, Small Intestine)</i></p>	
<ul style="list-style-type: none"> <input type="checkbox"/> Anxiety / Restlessness <input type="checkbox"/> Sores on tip of Tongue, speech problems <input type="checkbox"/> Trouble falling / Staying asleep <input type="checkbox"/> waking up unrefreshed, tired 	<ul style="list-style-type: none"> <input type="checkbox"/> Frequent Dreams <input type="checkbox"/> Mental Sluggishness / Fogginess <input type="checkbox"/> Inability to focus (ADD, ADHD) <input type="checkbox"/> Chest Pain traveling to shoulder
<ul style="list-style-type: none"> <input type="checkbox"/> Fast heart beat (>100 beats/min) <input type="checkbox"/> Slow heart beat (<50 beats/min) <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Palpitations / Heart Fluttering 	

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LIVER System Function <i>(Gall Bladder, Pineal Gland)</i>	KIDNEY System Function <i>(Urinary Bladder, Adrenal Glands)</i>
<ul style="list-style-type: none"> <input type="checkbox"/> Alternating Diarrhea & Constipation <input type="checkbox"/> Tight sensation in the chest <input type="checkbox"/> Bitter taste in the mouth <input type="checkbox"/> Irritable, Angry & frustrated frequently <input type="checkbox"/> Mood Swings <input type="checkbox"/> suffer from depression <input type="checkbox"/> Skin Rashes (redness, itching) <input type="checkbox"/> Headache at the top & sides of the Head, Migraines <input type="checkbox"/> Numbness / Tingling Sensation <input type="checkbox"/> Muscle Twitching / Cramping / Spasms <input type="checkbox"/> Seizures / Convulsions, tremors, tics <input type="checkbox"/> Lump in the throat <input type="checkbox"/> Neck & Shoulder Tension / tightness / pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> TMJ pain <input type="checkbox"/> High-pitched ringing in ears <input type="checkbox"/> Difficulty adapting to stress, teeth grinding <input type="checkbox"/> Dizziness / poor balance / vertigo <p>EYES/VISION</p> <ul style="list-style-type: none"> <input type="checkbox"/> Itchy Eyes <input type="checkbox"/> Blood Shot Eyes <input type="checkbox"/> Burning Eyes <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Watery Eyes <input type="checkbox"/> Gritty Eyes <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Decreased Night Vision <input type="checkbox"/> Floaters in the eyes 	<ul style="list-style-type: none"> <input type="checkbox"/> Cold Hands & Feet <input type="checkbox"/> Feels cold all the time whole body <input type="checkbox"/> Hot Flashes & Night Sweats <input type="checkbox"/> Thirsty all the time <input type="checkbox"/> Frequent cavities, teeth problems <input type="checkbox"/> Sore Achy / Weak Knees <input type="checkbox"/> Lower Back Pain <input type="checkbox"/> Memory Problems (short term & long term) <input type="checkbox"/> Excessive hair loss, premature greying of hair <input type="checkbox"/> Low-pitched ringing in the ears <input type="checkbox"/> Poor Hearing / Hearing problems <p>URINATION</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of bladder control (incontinence) <input type="checkbox"/> Wake during the night >1 time to urinate? <input type="checkbox"/> Scanty Urination <input type="checkbox"/> Profuse Urination <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Difficult / Incomplete urination <input type="checkbox"/> Painful / Burning urination <input type="checkbox"/> Cloudy Urine <input type="checkbox"/> Reddish urine <ul style="list-style-type: none"> <input type="checkbox"/> history of chronic fear <input type="checkbox"/> Easily startled <input type="checkbox"/> General Weakness, low energy, chronic fatigue <input type="checkbox"/> Low or No Libido <input type="checkbox"/> Excessively high libido <p>FOR MEN ONLY</p> <ul style="list-style-type: none"> <input type="checkbox"/> swollen testes <input type="checkbox"/> Testicular Pain <input type="checkbox"/> Inability to maintain erection <input type="checkbox"/> Premature ejaculation

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Yen Acupuncture & Herbal Clinic, Inc. dba Achieve Integrative Health

(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of the clinic's Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial all below:

_____ I acknowledge that it is the policy of Yen Acupuncture & Herbal Clinic, Inc dba Achieve Integrative Health to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Jimmy Yen, about my concerns.



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INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counseling, and physical medicine services. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I hereby authorize Yen Acupuncture & Herbal Clinic, Inc. dba Achieve Integrative Health to release any information regarding my condition to the referring physician (if any) and/or to my insurance for the processing of any claim.

Prior to receiving care a health history and physical examination will be completed. These procedures will assist the practitioner in determining which modalities are needed, or if any further examinations or studies are required. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have read and understand the above consent form.

Patient's Signature: _____ Date: _____

Parent or Legal Guardian (if under 18) printed name: _____

Parent or Legal Guardian Signature: _____